KAMALA D. HARRIS
Attorney General of California
JANICE K. LACHMAN
Supervising Deputy Attorney General
GEOFFREY S. ALLEN
Deputy Attorney General
State Bar No. 193338
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 324-5341
Facsimile: (916) 327-8643
Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **RUBEN BUGARIN BARRANCO** **885 N. Los Gatos Lane** **Gilbert, AZ 85234** **Registered Nurse License No. 658942** Respondent.	Case No. 2013- 518 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN ("Complainant") brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

2. On or about June 15, 2005, the Board issued Registered Nurse License Number 658942 to Ruben Bugarin Barranco ("Respondent"). Respondent's registered nurse license was in full force and effect at all times relevant to the charges brought herein and will expire on February 28, 2013, unless renewed.

STATUTORY PROVISIONS

3. Business and Professions Code ("Code") section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive

license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

4. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811, subdivision (b), the Board may renew an expired license at any time within eight years after the expiration.

5. Code section 2761 states, in pertinent part:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct . . .
>
> . . . .
>
> (4) Denial of licensure, revocation, suspension, restriction, or any other disciplinary action against a health care professional license or certificate by another state or territory of the United States, by any other government agency, or by another California health care professional licensing board. A certified copy of the decision or judgment shall be conclusive evidence of that action . . .

COST RECOVERY

6. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licentiate to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

CAUSE FOR DISCIPLINE

(Disciplinary Action by the Arizona State Board of Nursing)

7. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a)(4), on the grounds of unprofessional conduct, in that he was disciplined by the Arizona State Board of Nursing ("Arizona Board"), as follows: On or about February 13, 2012, pursuant to Consent Agreement and Order No. 1010048, in the disciplinary proceeding titled "In the Matter of Registered Nurse License No. RN157291 Issued to: Ruben Bugarin Barranco", the

Arizona Board placed Respondent's license on probation for 24 months. A true and correct copy of Consent Agreement and Order No. 1010048 is attached as **exhibit A** and incorporated herein.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 658942, issued to Ruben Bugarin Barranco;

2. Ordering Ruben Bugarin Barranco to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: December 24, 2012

for LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

SA2012106164

EXHIBIT A

Arizona State Board of Nursing, Consent Agreement and Order No. 1010048

BEFORE THE ARIZONA STATE BOARD OF NURSING

IN THE MATTER OF REGISTERED NURSE LICENSE NO.: RN157291 ISSUED TO: RUBEN BUGARIN BARRANCO RESPONDENT	**CONSENT AGREEMENT AND ORDER NO. 1010048**

CONSENT AGREEMENT

A complaint charging RUBEN BUGARIN BARRANCO, ("Respondent") with violation of the Nurse Practice Act has been received by the Arizona State Board of Nursing ("Board"). In the interest of a prompt and speedy settlement of the above-captioned matter, consistent with the public interest, statutory requirements and the responsibilities of the Board, and pursuant to A.R.S. § 41-1092.07(F)(5), the undersigned parties enter into this Consent Agreement as a final disposition of this matter.

Based on the evidence before it, the Board makes the following Findings of Fact and Conclusions of Law:

FINDINGS OF FACT

1. Respondent holds Board issued registered nurse license no. RN157291.

2. On or about October 7, 2010, the Board received a complaint against Respondent's registered nurse license, from the Arizona Department of Health Services ["ADHS"], Office of Assisted Living Licensing State Team Leader, alleging that from in or about February 2010, to in or about June 2010, resident A.S., a medically complex and medically fragile individual, was living at the Scottsdale Manor Assisted Living ["SMAL"] facility in Scottsdale, Arizona. According to the ADHS report, Respondent was the owner and facility manager at SMAL. According to the ADHS report, from the time A.S. was admitted to SMAL, A.S. lost 49 pounds and developed 10 pressure sores and became infected with four antibiotic-

resistant infections. According to the ADHS report, A.S. was subsequently transferred from SMAL, to Mayo Clinic Hospital's Emergency Room, in Phoenix, Arizona. Mayo Clinic Hospital's Emergency Room physician diagnosed A.S. with multiple pressure sores/ulcerations [at various stages], malnutrition and wound infections. The ADHS report further alleged that Respondent failed to inform A.S.'s medical provider [Dr. G. O'Brien] about A.S.'s deteriorating condition, and only after A.S.'s transferred to Mayo Clinic Hospital, Respondent then created a false record for A.S. Based upon this information, the Board initiated an investigation.

3. On or about April 20, 2011, Board staff received A.S.'s SMAL medical file. Board staff reviewed A.S.'s file that reflected the following information:

a. A.S. was admitted to SMAL on February 8, 2010, and signed a "Residency Agreement" with Respondent;

b. On February 2, 2010, a "Resident Service Plan" ["RSP"] documented by Paradise Manor 1 while A.S. was a resident at their facility. The next due date for a review and revision of the plan was due on May 1, 2010;

c. On May 9, 2010, a "RSP" was documented and signed by Respondent. Respondent indicated that the next due date for a review and revision of the plan was August 9, 2010. Board staff compared the May 9, 2010 SMAL "RSP" with the February 2, 2010 Paradise Manor 1 "RSP." Board staff found that page one (1) of the SMAL and Paradise Manor "RSP" was identical, including handwriting. Respondent completed the information contained on page 2 through page 4 of the SMAL "RSP," which was identical to the February 2, 2010 Paradise Manor 1 "RSP" document, with the exception that the information was transcribed in Respondent's handwriting.

d. On February 20, 2010, a "progress note" written by Ann S., a SMAL caregiver reflected that A.S.'s left and right buttock skin areas were "intact" and applied "barrier cream to the affected areas" and repositioned A.S. every two hours. Ann S. notified Respondent and A.S.'s family [of the skin issues];

e. On February 25, 2010, a second "progress note" written by Ann. S, a SMAL caregiver noted that all skin problems on right and left buttocks were "completely healed" and notified Respondent of A.S.'s condition;

f. From on or about February 25, 2010, to on or about June 10, 2010, there were no progress notes in A.S.'s medical file;

g. On June 10, 2010, Respondent wrote a "progress note" reflecting the twice daily application of a skin barrier cream to A.S.'s right and left buttocks by SMAL caregivers. Respondent notified A.S.'s mother and physician Dr. O'Brien about the skin problems and Dr. O'Brien approved the use of the skin barrier cream;

h. On June 15, 2010, Respondent wrote a "progress note" reflecting he called Dr. O'Brien about A.S.s' right and left buttock wounds, and bilateral heel ulcers were not healing. Respondent documented that he recommended a Home Health Nurse to assess A.S.'s wounds;

i. On June 17, 2010, Respondent wrote a "progress note" reflecting that he called and left a voicemail message with the Bridgeway Case Manager in order to obtain authorization for RN visits for A.S.;

j. On June 18, 2010, Respondent wrote a "progress note" reflecting that a Home Health Nurse admitted A.S. to their home care service;

k. On June 19, 2010, Respondent wrote a "progress note" reflecting that a Wound Care Nurse from a Home Health Service saw A.S. and performed "routine wound care." Respondent documented that the home health nurse recommended transferring A.S. a hospital for medical treatment. Respondent notified A.S.'s mother and Dr. O'Brien about the transfer of care to Mayo Clinic Hospital; and

l. Communication notes about the status of A.S.'s skin/wound conditions between Respondent and A.S.'s physician, were sent via facsimile on purported dates of June 16, 2010, June 17, 2010 and June 18, 2010. The time stamp on the facsimile documents returned to SMAL by A.S.'s physician reflected a date of July 28, 2010, nearly five weeks after A.S. discharge from SMAL and his admission to Mayo Clinic Hospital.

4. Board staff reviewed A.S.'s medical record from Mayo Clinic Hospital ["MCH"], which reflected the following information:

a. On June 19, 2010, A.S. was admitted to the MCH, in Phoenix, Arizona for the medical evaluation and treatment of multiple pressure sores in various degrees of severity;

b. On June 19, 2010, at admission, A.S. weighed 62.1 kg or 136.2 pounds, a loss of approximately 49 pounds since February 8, 2010. According to Respondent, A.S.'s weight on admission to SMAL was an estimated weight by a caregiver, not actual weight;

c. On June 19, 2010, an Emergency Room physician described A.S. a right ankle ulceration with redness and swelling, suggestive of cellulites (infection of the skin). A.S.'s right ankle pressure ulcer was 1 cm by 2 cm, left ankle pressure ulcer was 2 cm by 1 cm, coccyx-sacral area had a Stage III pressure sore. The level of ulceration on A.S.'s right foot was deemed "unstageable (sic) or severe" and then on June 21, the ulceration was measured at 5 cm by 1 cm;

d. On June 19, 2010, an Emergency Room Physician's Assistant wrote in the progress notes, that Respondent told her that A.S.'s feet ulcers developed "...over the last few days." Respondent asserted that on June 18, 2010, A.S.'s primary care physician ordered an antibiotic;

e. On June 20, 2010, a physician determined that A.S. had osteomyelitis [bone infection] related to foot and ankle ulcerations and had an antibiotic-resistant infection. On June 22, 2010 a physician determined the cause of A.S.'s pressure ulcers were likely "... a combination of suboptimal positioning both in bed and in the wheelchair."

5. Board staff received a copy of a January 3, 2011 Arizona State Board of Examiners of Nursing Care Institution Administrators and Assisted Living Facility *Consent Agreement and Order for Voluntary Surrender", Complaint No. 11-09, "In the Matter of Ruben B. Barranco, Holder of Assisted Living Facility Manager's Certificate No. 09654"* [attached and incorporated as Exhibit A].

6. On or about April 20, 2011, during an interview with Board staff, Respondent denied the allegations in the Board's complaint and asserted that he appropriately intervened on A.S.'s behalf as the Assisted Living Manager at SMAL. Respondent stated that he never assessed the status of A.S.'s skin breakdown/wounds, which contradicts his written statement in Board investigative questionnaire submitted on November 10, 2010.

7. On or about April 20, 2011, during an interview with Board staff, Respondent admitted that while he was the SMAL facility Manager, he was initially living in San Francisco, California during the relevant time period and commuted back and forth between his homes. Respondent asserted when he was not at the facility/out of state, he delegated his managerial

duties and authority to "appropriate staff members" and also communicated with them telephonically during the week.

Respondent asserted that he was usually at SMAL at least three times a week and on no occasion observed A.S. to have any significant weight loss.

8. On or about April 20, 2011, during an interview with Board staff, Respondent asserted that he was currently working as a "financial consultant" at the Higley Assisted Living Center ["HALC"], in Gilbert, Arizona. Respondent described HALC as a "group home," and functions without caregivers and does not provide skilled nursing care. Respondent stated that his former SMAL business partner, R. Hapan, owned and managed HALC. Respondent denied functioning in the capacity as a manager or was a co-owner of HALC.

9. On or about May 9, 2011, Board staff reviewed the Arizona State Corporation Commission ["ASCC"] website database and identified the following information regarding Respondent's connection to HALC:

a. On or about May 29, 2008, HALC corporation was initiated;
b. The Statutory Agent and Director is listed as Respondent ["Ruben Barranco"], and R. Hapan is also listed as a HALC Director;
c. Respondent is listed as HALC's "President and CEO" and took office effective September 29, 2009; and
c. HACL's address corresponds to Respondent's address of record that he recorded on his November 20, 2010 Board investigative questionnaire.

10. On or about May 9, 2010, Board staff learned from the ADHS, State Licensing Team Leader, with the Office of Assisted Living Licensing the following information:

a. HACL provided the ADHS Office of Assisted Living Licensing with documentation stating that Respondent was not affiliated in any way with HACL; and
b. ADHS conduct a recent survey at Mountain Vista Manor and found Respondent working at this facility as a "caregiver and/or nurse."

Respondent failed to disclose Mountain Vista Manor to Board staff during the Board's investigation as part of his employment history.

CONCLUSIONS OF LAW

Pursuant to A.R.S. §§ 32-1606, 32-1663 and 32-1664, the Board has subject matter and personal jurisdiction in this matter.

The conduct and circumstances described in the Findings of Fact constitute violations of A.R.S. § 32-1663 (D) as defined in § 32-1601(18) ("Unprofessional conduct" includes the following whether occurring in this state or elsewhere:) (d) (Any practice or conduct that is or might be harmful to the health of a patient or the public); (f) (Having a license, certificate, permit or registration to practice a health care profession denied, suspended, conditioned, limited or revoked in another jurisdiction and not reinstated by that jurisdiction); (h) (Committing an act that deceives, defrauds or harms the public); and (j) (Violating this chapter or a rule that is adopted by the board pursuant to this chapter) (effective September 30, 2009), specifically:

- A.A.C. R4-19-403 (2) (Intentionally or negligently causing physical or emotional injury) (effective January 30, 2009);
- A.AC. R4-19-403 (5) (Abandoning or neglecting a patient who requires immediate nursing care without making reasonable arrangement for continuation of care) (effective January 30, 2009);
- A.A.C. R4-19-403 (7) (Failing to maintain for a patient record that accurately reflects the nursing assessment, care, treatment, and other nursing services provided to the patient) (effective January 30, 2009);

- A.A.C. R4-19-403 (8a) (Falsifying or making materially incorrect, inconsistent, or unintelligible entry in any record:) (Regarding a patient, health care facility, school, institution, or other work place location) (effective January 30, 2009);
- A.A.C. R4-19-403 (9) (Failing to take appropriate action to safeguard a patient's welfare or follow policies and procedures of the nurse's employer designed to safeguard the patient) (effective January 30, 2009);
- A.A.C. R4-19-403 (10) (Failing to take action in a health care setting to prevent a patient whose safety or welfare is at risk from incompetent health care practice, to report the incompetent health care practice to employment of licensing authorities) (effective January 30, 2009);
- A.A.C. R4-19-403 (13) (Failing to supervise a person to whom nursing functions are delegated) (effective January 30, 2009);
- A.A.C. R4-19-403 (26) (Making a false or inaccurate statement to the Board or the Board's designee in the course of an investigation) (effective January 30, 2009); and
- A.A.C. R4-19-403 (31) (Practicing in any other manner that gives the Board reasonable cause to believe the health of a patient or the public may be harmed) (effective January 30, 2009).

The conduct and circumstances described in the Findings of Fact constitute sufficient cause pursuant to A.R.S. § 32-1664(N) to revoke, suspend or take other disciplinary action against Respondent's license to practice as a registered nurse in the State of Arizona.

Respondent admits the Board's Findings of Fact and Conclusions of Law for the purposes of resolving this matter without the complexities and costs of a hearing.

In lieu of a formal hearing on these issues, Respondent agrees to issuance of the attached Order and waives all rights to a hearing, rehearing, appeal or judicial review relating to this matter. Respondent further waives any and all claims or causes of action, whether known or unknown, that Respondent may have against the State of Arizona, the Board, its members, offices, employees and/or agents arising out of this matter.

Respondent understands that all investigative materials prepared or received by the Board concerning these violations and all notices and pleadings relating thereto may be retained in the Board's file concerning this matter.

Respondent understands that the admissions in the Findings of Fact are conclusive evidence of a violation of the Nurse Practice Act and may be used for purposes of determining sanctions in any future disciplinary matter.

Respondent understands the right to consult legal counsel prior to entering into this Consent Agreement and such consultation has either been obtained or is waived.

Respondent understands that this Consent Agreement is effective upon its acceptance by the Board and by Respondent as evidenced by the respective signatures thereto. Respondent's signature obtained via facsimile shall have the same effect as an original signature. Once signed by Respondent, the Agreement cannot be withdrawn without the Board's approval or by stipulation between Respondent and the Board's designee. The effective date of this Order is the date the Consent Agreement is signed by the Board and by Respondent. If the Consent

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/ / / / /

Agreement is signed on different dates, the later date is the effective date.

Respondent

Dated: 02/13/2012

ARIZONA STATE BOARD OF NURSING

SEAL

Joey Ridenour RN MN FAAN

Joey Ridenour, R.N., M.N., F.A.A.N.
Executive Director

Dated: May 26, 2011

SMITH/RN15729I/BARRANCO

ORDER

In view of the above Findings of Fact, Conclusions of Law and the consent of Respondent, the Board hereby issues the following Order:

A. Respondent's consent to the terms and conditions of the Order and waiver of public hearing is accepted.

B. Respondent's license is placed on probation for 24-months. Prior to termination of probation, Respondent shall work as a registered nurse for a minimum of 24-months (not less than sixteen hours a week).

C. This Order becomes effective upon the Board and Respondent's acceptance of the Consent Agreement. The effective date of this Order is the date the Consent Agreement is signed by the Board and by Respondent. If the Consent agreement is signed on different dates, the later is the effective date. Probation is to commence the effective date of this Order.

D. If Respondent is noncompliant with any of the terms of the Order, Respondent's noncompliance shall be reviewed by the Board for consideration of possible further discipline on Respondent's nursing license.

E. If Respondent is convicted of a felony, Respondent's license shall be automatically revoked for a period of five years. Respondent waives any and all rights to a hearing, rehearing or judicial review of any revocation imposed pursuant to this paragraph.

F. Probation is subject to the following terms and conditions:

TERMS OF PROBATION

1. Stamping of License

Within seven (7) days of the effective date of this Order, Respondent shall submit his license to be stamped **"PROBATION."** While this Order is in effect, if the Board issues any certificates or licenses authorized by statute, except a nursing assistant certificate, such certificate or license shall also be stamped "probation." Respondent is not eligible for a multistate "Compact" license.

2. Ethical Aspects of Nursing

Within 30 days from the effective date of this Order, Respondent shall make an appointment to undergo a nursing ethics course or may begin nursing ethics counseling by a Board-approved treatment professional. If Respondent chooses to fulfill this stipulation by participation in counseling, Respondent shall execute the appropriate release of information form(s) to allow the counselor to communicate information to the Board or its designee. Prior to beginning the course or counseling, Respondent shall furnish a copy of this Consent Agreement and Order to include Findings of Fact and Conclusions of Law to the counselor or course director. Respondent shall cause the course director or counselor to notify the Board in writing

within 30 days of entry into the course or therapy, and to verify in that same letter receipt of the Consent Agreement and Order to include Findings of Fact.

Respondent shall undergo and continue treatment or course attendance until the course director or treatment professional determines and reports to the Board in writing and on letterhead, that Respondent successfully completed the Ethics Course or that treatment is no longer considered necessary by the treating professional. During the duration of the course of counseling Respondent shall have the treatment professional or course director provide written reports to the Board every three months [quarterly reports]. The Board reserves the right to amend this Order as it relates to education and practice remediation based on the recommendations of the course director or treatment professional.

3. Legal Aspects of Nursing Documentation Course

Within 30 days of the effective date of this Order, Respondent shall submit to the Board or its designee for prior approval a course outline/objectives of an educational course or program related to *nursing documentation and/or the legal aspects of nursing documentation*. Respondent shall then provide written proof from the instructor or provider of the course verifying enrollment, attendance, and successful completion of each required course or program. Following the successful completion of each course or program, the Board or its designee may administer an examination to test Respondent's knowledge of the course or program content. The Board reserves the right to amend the Order as it relates to education and practice remediation based on the recommendation(s) of the course instructor.

4. Wound Care Management Course

Within 30 days of the effective date of this Order, Respondent shall submit to the Board or its designee for prior approval a course outline/objectives of an educational course or

program related to *wound care management*. **This course/program shall not be an online or long-distance learning course/program.** Respondent shall then provide written proof from the instructor or provider of the course verifying enrollment, attendance, and successful completion of each required course or program. Following the successful completion of each course or program, the Board or its designee may administer an examination to test Respondent's knowledge of the course or program content. The Board reserves the right to amend the Order as it relates to education and practice remediation based on the recommendation(s) of the course instructor.

5. Healthcare Professional Communication Course

Within 30 days of the effective date of this Order, Respondent shall submit to the Board or its designee for prior approval a course outline/objectives of an educational course or program related to *healthcare professional communication and the delegation of duties to licensed and non-licensed personnel*. Respondent shall then provide written proof from the instructor or provider of the course verifying enrollment, attendance, and successful completion of each required course or program. Following the successful completion of each course or program, the Board or its designee may administer an examination to test Respondent's knowledge of the course or program content. The Board reserves the right to amend the Order as it relates to education and practice remediation based on the recommendation(s) of the course instructor.

6. Notification of Practice Settings

Any setting in which Respondent is currently employed shall be provided with a copy of the entire Order within three days of the effective date of the Order. Respondent shall cause his immediate supervisor to inform the Board, in writing and on employer letterhead,

acknowledgment of the supervisor's receipt of a copy of this Consent Agreement and Order and the employer's ability to comply with the conditions of probation. Thereafter, any setting in which Respondent accepts employment, which requires RN licensure, shall be provided with a copy of the entire Order on or before the date of hire. Within three (3) calendar days of Respondent's date of hire, Respondent shall cause his immediate supervisor to inform the Board, in writing and on employer letterhead, acknowledgment of the supervisor's receipt of a copy of this Consent Agreement and Order and the employer's ability to comply with the conditions of probation. In the event Respondent is attending a nursing program, Respondent shall provide a copy of the entire Consent Agreement and Order to the Program Director. Respondent shall cause the Program Director to inform the Board, in writing and on school letterhead, acknowledgment of the program's receipt of a copy of the Consent Agreement and Order and the program's ability to comply with the conditions of probation during clinical experiences.

7. Quarterly Reports

Within seven (7) days of each assigned quarterly reporting due date, if Respondent is working in any position which requires RN licensure Respondent shall cause **every** employer Respondent has worked for during the quarter to provide to the Board, in writing, employer evaluations on the Board-approved form. The first report is due on the first assigned quarterly report due date after the effective date of the Order. Receipt of notice of an unsatisfactory employer evaluation, verbal or written warning, counseling or disciplinary action any of which pertain to patient care practice issues, or termination from a place of employment shall be considered as noncompliance with the terms of the Order. In the event Respondent is not working in a position which required RN licensure, or attending school during any quarter or portion thereof, Respondent shall provide to the Board, in writing, a quarterly self-report

describing other employment or activities on the Board-approved form. Failure to provide employer evaluations/or self-reports within seven (7) days of the reporting date shall be considered as noncompliance with the terms of the Order.

8. Practice Under On-Site Supervision

Respondent shall practice as a registered nurse only under the on-site supervision of a registered nurse in good standing with the Board. *On-site supervision is defined as having a registered nurse in present in the building while Respondent is on duty.* The supervising nurse shall have read this Consent Agreement and Order to include the Findings of Fact and Conclusions of Law, and Order, and shall provide input on Respondent's employer evaluations to the Board. The supervising nurse shall be primarily one person, who may periodically delegate to other qualified personnel, who shall also have read this Consent Agreement and Order to include Findings of Fact, Conclusions of Law. In the event that the assigned supervising nurse is no longer responsible for the supervision required by this paragraph, Respondent shall cause his new supervising nurse to inform the Board, in writing and on employer letterhead, acknowledgment of the new supervisor's receipt of a copy of this Consent Agreement and Order to include the Findings of Fact and Conclusions of Law and the new supervising nurse's agreement to comply with the conditions of probation within ten days of assignment of a new supervising nurse.

9. Acceptable Hours of Work

Respondent shall work only the day or evening shift. Evening shift is defined as a shift that ends prior to midnight. Within a 14-day period Respondent shall not work more than 84 scheduled hours.

Respondent may work three 12-hour shifts in one seven day period and four 12-hour shifts in the other seven-day period, but Respondent may not work more than 3 consecutive 12-hour shifts during this probationary period. Respondent shall not work 2 consecutive 8-hour shifts within a 24-hour period or be scheduled to work 16 hours within a 24-hour period.

10. Registry Work Prohibited

Respondent may not work for a nurse's registry, home health, traveling nurse agency, any other temporary employing agencies, float pool, or position that requires on-call status. **Respondent shall not be permitted to fulfill his probationary work requirement as an employee of an Assisted Living Facility or in any other health care setting where "on-site" supervision is not present.**

11. Out-of-State Practice/Residence

Before any out-of-state practice or residence can be credited toward fulfillment of these terms and conditions, it must first be approved by the Board prior to leaving the state. If Respondent fails to receive such approval before leaving the state, none of the time spent out-of-state will be credited to the fulfillment of the terms and conditions of this Order.

12. Release of Information Forms

Respondent shall sign all release of information forms as required by the Board or its designee and return them to the Board within 10 days of the Board's written request. Failure to provide for the release of information, as required by this paragraph constitutes non-compliance with this Order.

13. Interview With the Board or Its Designee

Respondent shall appear in person or if residing out of state telephonically for interviews with the Board or its designee upon request at various intervals and with reasonable notice.

14. Renewal of License

In the event Respondent's registered nurse license is scheduled to expire while this Order is in effect, Respondent shall apply for renewal of the license, pay the applicable fee, and otherwise maintain qualification to practice nursing in Arizona.

15. Change of Employment/Personal Address/Telephone Number

Respondent shall notify the Board, in writing, within seven (7) days of any change in nursing employment, personal address or telephone number. Changes in nursing employment include the acceptance, resignation or termination or employment.

16. Obey All Laws

Respondent shall obey all laws/rules governing the practice of nursing in this state and obey all federal, state and local criminal laws. Respondent shall report to the Board, within 10 days, any misdemeanor or felony arrest or conviction.

17. Costs

Respondent shall bear all costs of complying with this Order.

18. Violation of Probation

If Respondent is noncompliant with this Order in any respect, the Board or its designee may notify Respondent's employer of the noncompliance. Additionally, the Board may revoke probation and take further disciplinary action for noncompliance with this Order after affording Respondent notice and the opportunity to be heard. If a complaint or petition to revoke probation is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

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19. Voluntary Surrender of License

Respondent may, at any time this Order is in effect, voluntarily request surrender of his license.

20. Completion of Probation

Respondent is not eligible for early termination of this Order. Upon successful completion of the terms of probation, Respondent shall request formal review by the Board, and after formal review by the Board, Respondent's nursing license may be fully restored by the appropriate Board action if compliance with this Order has been demonstrated.

ARIZONA STATE BOARD OF NURSING

SEAL

Joey Ridenour RN MN FAAN

Joey Ridenour, R.N., M.N., F.A.A.N.
Executive Director

Dated: May 26, 2011

JR/as:ts

EXECUTED SEALED COPIES mailed this 14th day of February, 2012 by First Class Mail, to:

Robert Sewell
Davis Miles, PLLC
80 E Rio Saldo Parkway, Suite 401
Tempe, AZ 85281
Attorney for Ruben Bugarin Barranco

AND

Ruben Bugarin Barranco
885 N Los Gatos Lane
Gilbert, AZ 85234

By: Trina Smith
Legal Secretary

[EXHIBIT A]

BEFORE THE BOARD OF EXAMINERS OF NURSING CARE INSTITUION ADMINISTRATORS AND ASSISTED LIVING FACILITY MANAGERS

In the Matter of: **Ruben B. Barranco,** Holder of Assisted Living Facility Manager's Certificate No. 09654	Complaint No. 11-09 **CONSENT AGREEMENT AND ORDER FOR VOLUNTARY SURRENDER**

In order to resolve this complaint informally and to be consistent with the public interest, statutory requirements and responsibilities of the Board, pursuant to A.R.S. §41-1092.07(F)(5), and A.R.S. §33-446 *et seq.*, Ruben B. Barranco (Respondent), holder of certificate number 09654 to practice as an assisted living facility manager in the State of Arizona, and the Board enter into the following Recitals, Findings of Fact, Conclusions of Law and Order ("Consent Agreement") as the final disposition of this matter.

1. Respondent has read and understands this Consent Agreement, and has had the opportunity to discuss it with an attorney or has waived that opportunity. Respondent voluntarily enters into this Consent Agreement for the purpose of avoiding the expense and uncertainty of an administrative hearing.

2. Respondent understands that he has a right to a public administrative hearing concerning each and every allegation set forth in the above-captioned matter, at which administrative hearing he could present evidence and cross-examine witnesses. By entering into this Consent Agreement, Respondent freely and voluntarily relinquishes all right to such an administrative hearing, as well as all rights of rehearing, review, reconsideration, appeal, judicial review or any other administrative and/or judicial action, concerning the matters set forth herein. Respondent affirmatively agrees that this Consent Agreement shall be irrevocable.

3. Respondent agrees that the Board may adopt this Consent Agreement or any part of it, pursuant to A.R.S. §36-446.07(L). Respondent understands that the Board may consider this Consent Agreement or any part of it in any future disciplinary action against her.

4. Respondent understands that this Consent Agreement does not constitute a dismissal or resolution of other matters currently pending before the Board, *if any*, and does not constitute any waiver, express or implied, of the Board's statutory authority or jurisdiction regarding any other pending or future investigation, action or proceeding. Respondent also understands that acceptance of this Consent Agreement does not preclude any other agency, subdivision or officer of this state from instituting other civil or criminal proceedings with respect to the conduct that is the subject of this Consent Agreement.

5. All admissions Respondent makes in this Consent Agreement are made solely for the final disposition of this matter, and any related administrative proceedings or civil litigation involving the Board and Respondent. This Consent Agreement is not intended to be used for any other regulatory agency proceedings, or civil or criminal proceedings, whether in the State of Arizona or any other state or federal court, except related to the enforcement of the Consent Agreement itself.

6. Respondent acknowledges and agrees that, upon signing this Consent Agreement and returning this document to the Board, Respondent may not revoke his acceptance of the Consent Agreement or make any modifications to the document. Any modification to this original document is ineffective and void unless mutually approved by the parties in writing.

7. Respondent understands that the foregoing Consent Agreement shall not become effective unless and until the Board adopts it and the Executive Director signs it.

8. Respondent understands and agrees that if the Board does not adopt this Consent Agreement, he will not assert as a defense that the Board's consideration of it constitutes bias, prejudice, prejudgment or other similar defense in any future disciplinary action.

9. Respondent understands that this Consent Agreement is a public record that may be publicly disseminated as a formal action of the Board, and shall be reported as required by law to the National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank.

10. Respondent understands that any violation of this Consent Agreement constitutes unprofessional conduct pursuant to A.R.S. §36-446(9).

12-29-10
DATED

Ruben B. Barranco
Respondent

FINDINGS OF FACT

1. The Board of Examiners of Nursing Care Institution Administrators and Assisted Living Facility Managers, ("Board,") is the duly constituted authority for licensing and regulating the practice of Nursing Care Institution Administrators and Assisted Living Facility Managers in the State of Arizona.

2. Ruben B. Barranco, ("Respondent") holds Assisted Living Facility Manager's Certificate No.09654.

3. Respondent managed Scottsdale Manor Assisted Living Inc, ("the facility") located at 5645 E. Nisbet Road in Scottsdale, Arizona.

4. On April 6 and 7, 2010, the Arizona Department of Health Services (DHS) conducted an Assisted Living Home Change of Ownership Compliance Inspection at the facility. The Inspection identified thirty-three (33) deficiencies in thirteen (13) different areas.

5. On July 22, 2010, DHS took enforcement action and imposed a Civil Money Penalty of $3600 upon the facility licensee, Scottsdale Manor Assisted Living Inc, for failure to administer medications per physician orders to one resident, and for initialing medication administration records even though the medications were not administered to the resident. Respondent subsequently surrendered the facility license to DHS.

6. During the December 13, 2010 meeting, Respondent discussed with the Board the deficiencies DHS identified and substantiated at the care home he managed. Based on Respondent's comments and the evidence in the record, the Board determined that Respondent was responsible for the substantiated violations and that his actions, or lack thereof, fell below the Standard of Care for Managers and could have caused harm to the residents and the public.

CONCLUSIONS OF LAW

7. The conduct and circumstances explained in the Factual Allegations in Paragraphs 4 through 6 constitute a violation of A.R.S. §36-446.07(B) (3), as defined in A.R.S. §36-446(9)(a), in that Respondent's actions or inactions as the manager of the facility, involved incompetency or gross negligence in the performance of his administrative duties.

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law, the parties agree to the provisions and penalties imposed as follows:

IT IS HEREBY ORDERED that Ruben B. Barranco, holder of certificate number 09654, as an assisted living facility manager in the State of Arizona, shall surrender his certificate to the Board within ten (10) days of the effective date of this Consent Agreement.

DATED AND EFFECTIVE this 3rd day of JANUARY, 2011.

BOARD OF EXAMINERS OF NURSING CARE INSTITUTION ADMINISTRATORS AND ASSISTED LIVING FACILITY MANAGERS

(SEAL)

By:
Allen Imig
Executive Director

Original of the foregoing filed this
20th day of December, 2010, with:

Allen Imig
NCIA Executive Director
1400 W. Washington, Ste. B-8
Phoenix, AZ 85007

COPY of the foregoing mailed by U.S Mail
This 20th day of December, 2010, to:

Ruben B. Barranco
885 N. Los Gatos Lane
Gilbert, Arizona 85234

COPIES of the foregoing mailed
This 20th day of December, 2010, to:

Keely Verstegen
Assistant Attorney General
1275 W. Washington, CIV/LES
Phoenix, Arizona 85007